HIGHLIGHTS (10 Apr 2020)

- As of 5 April, 9 COVID-19 cases were confirmed in Zimbabwe, including one death, with 340 suspected cases testing negative.

- After a disruption of one week, food and cash distributions were resumed on 30 March with food assistance provided to 740,000 people and mobile money transfers to 60,000 people.

- More than 2,500 children under age 5 have been admitted for treatment of severe acute malnutrition in 2020.

- The ZimVAC 2020 indicates that the national global acute malnutrition prevalence is 3.7 per cent and the national severe acute malnutrition prevalence 1.45 per cent.

- 198 families displaced due to Cyclone Idai remain in camps exposed to protection and health risks.

KEY FIGURES

- 7M people in need
- 5.6M people targeted
- 47 partners operational

FUNDING (2020)

- $715.8M Required
- $62M Received
- 9% Progress

FTS: https://fts.unocha.org/appeals/921/summary

CONTACTS

- Wouter De Cuyper
  Humanitarian Affairs Officer, Zimbabwe
decuyper@un.org

- Guiomar Pau Sole
  Communications & Information Management, Regional Office for Southern & Eastern Africa
pausole@un.org
BACKGROUND  (10 Apr 2020)

Situation Overview

Across Zimbabwe, 7 million people in urban and rural areas are in urgent need of humanitarian assistance, compared to 5.5 million in August 2019. Since the launch of the Revised Humanitarian Appeal in August 2019, circumstances for millions of Zimbabweans have worsened. Drought and crop failure, exacerbated by macro-economic challenges and austerity measures, have directly affected vulnerable households in both rural and urban communities. Inflation continues to erode purchasing power and affordability of food and other essential goods is a daily challenge. The delivery of healthcare, clean water and sanitation, and education has been constrained and millions of people are facing challenges to access vital services. There are more than 4.3 million people severely food insecure in rural areas in Zimbabwe, according to the latest Integrated Food Security Phase Classification (IPC) analysis, undertaken in February 2020. In addition, 2.2 million people in urban areas, are “cereal food insecure,” according to the most recent Vulnerability Assessment Committee (ZimVAC) analysis. Erratic and late 2019/2020 rains forebode the possibility of a second poor harvest. Nutritional needs remain high with over 1.1 million children and women requiring nutrition assistance. At least 4 million vulnerable Zimbabweans are facing challenges accessing primary healthcare and drought conditions trigger several health risks. Decreasing availability of safe water, sanitation and hygiene have heightened the risk of communicable disease outbreaks for 3.7 million vulnerable people. Some 1.2 million school-age children are facing challenges accessing education. The drought and economic situation have heightened protection risks, particularly for women and children. Ten months after Cyclone Idai hit Zimbabwe, 128,270 people remain in need of humanitarian assistance across the 12 affected districts in Manicaland and Masvingo provinces. There are 21,328 refugees and asylum seekers in Zimbabwe who need international protection and multisectoral life-saving assistance to enable them to live in safety and dignity. As of 8 April, the Ministry of Health and Child Care (MOHCC) in Zimbabwe had reported 11 confirmed COVID-19 cases including two death, as well as at least 340 suspected cases of COVID-19 which tested negative. With the first cases reported in Zimbabwe as of 20 March, and the recent increase of COVID-19 transmission in the region, the Government of Zimbabwe is strengthening and accelerating preparedness and response to the COVID-19 outbreak. Following the declaration of COVID-19 as a national disaster on 19 March 2020, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched with an initial eight pillars of coordination, the creation of a national COVID-19 Response Task Force and the formation of the Inter-Ministerial Committee. The Government of Zimbabwe declared a 21-day nationwide lockdown starting on 30 March 2020 ensuring the continuity of essential services.

CLUSTER STATUS  (10 Apr 2020)

Camp Coordination and Camp Management / Shelter and NFIs

198 families in camps

Needs

- Some 198 Cyclone Idai-affected families remain in camps, where living conditions are exposing them to serious protection and health risks.
- Shelter support is needed for those remaining in the camps and for affected and displaced people accommodated in host communities or in makeshift structures already worn out for the protracted crisis.
• The possibility of relocation of IDPs in camps is not feasible in a short term and is anticipated that IDPs will remain in the camps for a period of six to nine more months.

• The Government has asked support to replace tents by semi-permanent transitional shelter structures.

• There is a need for Camp Coordination and Camp Management (CCCM) activities, including accountability for affected people.

• The camp infrastructure needs upgrading.

Response

• Technical support for the Government in developing a camp exit strategy and operationalization of the permanent relocation plan is ongoing.

• Construction of new houses and rehabilitation in host communities is underway.

• The continuous monitoring of IDPs through DTM assessments to track mobility, vulnerability and needs remains a high priority.

Gaps

• Due to the bad conditions of the camps, and recent weather conditions, there is urgent need to breach the shelter gap and contrast semi-permanent structures to support the displaced population.

CLUSTER STATUS (10 Apr 2020)

Education

853k people targeted

Needs

• The humanitarian crisis in Zimbabwe is expected to have far-reaching implications for school readiness, attendance and participation. The Education Cluster estimates that, of the more than 3.4 million children of school going age (3 to 12 years), at least 1.2 million (35 per cent), will need emergency and specialized education services in 2020. This includes more than 853,000 children in acute need, such as: children not enrolled in school; orphans and other vulnerable children, including children with disabilities and children living with HIV, and those in need of school feeding.

• The education system in Zimbabwe was already stretched before the COVID-19 pandemic as a result of multiple crises, including the impact of Cyclone Idai last year, the economic crisis coupled with hyperinflation and the ongoing drought. Without a well-resourced response, the combined impact of these crises risks having a lasting negative childrens’ education and increasing drop outs. Without a conducive and disease-free school environment, COVID-19 poses a risk to children’s health and wellbeing.

Response
As of 1 January 2020, the cluster through operation partners was able to reach a total of 10,869 people through various activities including construction/rehabilitation of latrines (6,215), school feeding (3,125), distribution of school kits (1,500) and school fees interventions (29).

Cluster partners have been trained on reporting towards the 5W monitoring tool with expected increase of activities in coming months based on the recently launched HRP for Zimbabwe.

Meanwhile, with the onset of COVID-19 pandemic, the Zimbabwe Education Cluster has been developing a preparedness and response strategy for COVID-19, which goal is to minimize morbidity and mortality of COVID-19 among school communities, teachers and learners in Zimbabwe; minimize/mitigate the disruption to the children’s education and learning; and ensure safe return to quality learning for teachers, learners and school communities. The Cluster is currently working with partners to ensure streamlined reporting of these activities alongside the HRP specific activities.

**Gaps**

- Whereas partners had hoped to do a lot more, funding constraints continued to be the major drawback that militated against implementation of activities. Plans are underway to source resources in order to fund the overall humanitarian response as well as the COVID-19 strategy.

**CLUSTER STATUS (10 Apr 2020)**

**Food Security**

- **4.4M** people targeted
- **740K** people received food assistance

**Needs**

- According to the 2020 Humanitarian Response Plan, a total of 6 million people in rural and urban areas are in urgent need of food assistance across Zimbabwe both in rural and rural areas.

- In addition, 2.8 million small holder farmers are in need of season-sensitive emergency crop and livestock input assistance.

- Measures taken by the Government to mitigate to COVID-19 outbreak, in particular a country-wide lockdown, the restriction of cross-border movements and stringent conditions on humanitarian actors’ activities, might impact negatively food security across Zimbabwe. Those impacts are likely to trigger an increased reliance on negative coping strategy and reduced livelihoods opportunities for the most vulnerable.

- With social distancing standards due to COVID-19 impacting conventional training approaches, FAO is looking at remote training methods using social media.

**Response**
Despite operational constraints as a result of the new protocols for operating under COVID-19, including the guarantee of personal protection equipment (PPE), Food Security partners resumed food and cash distributions on 30 March after a disruption of one week. In March 2020, WFP provided food assistance to a total of 2,022,000 beneficiaries while INGOs implemented mobile money transfers to 98,000 beneficiaries. Other Cluster partners are resuming their food and cash distributions during the week of 13-17 April.

In February 2020, a total of 3.9 million people were reached with either food or cash assistance. A total of 840,000 people were reached with agriculture inputs, advisory services or community assets rehabilitation.

In January, a total 2.9 million of people were reached with cash or food distribution. The Food Security Cluster reached a total of 740,000 people to prevent further deterioration of living standards by providing emergency agriculture support aimed at ensuring they can achieve food security and resilience to repeated exposure to multiples hocks and stressors.

While WFP and other Cluster partners have procured PPE materials, the quantities received are not adequate to meet the needs country-wide, which jeopardizes partners ability to continue distributions from one week to another.

Furthermore, severe cash availability constraints make it difficult for partners to access the necessary hard currency to be able to procure PPE through local vendors, and hampers the Food Security Cluster ability to support government-designated health officials.

Some agricultural activities, such as fielding of consultants and training activities, have been temporarily suspended, and only limited critical activities are taking place.

Gaps

- Critical COVID-19 needs include the shortage of personal protection equipment (PPE); lack of equipped isolation facilities for treatment of severe COVID-19 patients; lack of specialized human resources, e.g. anesthetists, for treatment of COVID-19 patients; the need for mass scale up for contact tracing, scale up testing (with global shortage of test kits) for 4,000 suspect cases, and scale up of risk communication; and preparedness of health workers.

Needs

- As of 8 April, Zimbabwe has reported 11 confirmed cases with one death since the onset of the outbreak, as well as 340 suspected cases of COVID-19 which tested negative. The first imported case was reported on 21 March 2020 and local transmission started on 24 March.
The National Preparedness and Response Plan for COVID-19 has eight pillars, aligned to WHO’s global 2019 COVID-19 Strategic Preparedness and Response Plan, including (1) Coordination, Planning and Monitoring; (2) Risk Communication and Community Engagement (RCCE); (3) Surveillance, Rapid Response Teams and Case Investigation; (4) Points of Entry; (5) National Laboratories; (6) Infection Prevention and Control (IPC); (7) Case Management; (8) Operational Support and Logistics. Recently the pillars Resource Mobilization and Security were added.

Pillar meetings are being held on a daily basis to plan and monitor the implementation of the COVID-19 activities.

On 3 April, four COVID-19 pillars, Coordination, IPC, RCCE and Security, converged to leverage on a National Clean-Up Day and intensify the cleaning by adding disinfection of identified hotspots starting with Harare and its peri-urban environs. The program will be extended to the cities of Mutare, Bulawayo, Chinhoyi and Beitbridge.

With screening of passengers starting on 22 January 2020, as of 4 April, 16,645 passengers arriving from countries with confirmed COVID-19 cases were screened at various points of entry (PoEs) and are followed up on a daily basis as part of surveillance.

On 1 April 2020, the Surveillance pillar held a virtual training for the rapid response teams (RRT) for Hwange District on the use of surveillance tools including investigation, contact line listing, daily contact monitoring, and contact summary reporting forms. Case investigation and other surveillance tools for contact tracing have been developed and shared with the provinces, with contact tracing having been continued in Victoria Falls and Harare.

IPC and case management rapid assessments were completed for Harare, Wilkins, Parirenyatwa and St. Annes medical facilities, with subnational and other institutions expected to conduct assessments in preparation of Covid-19 cases. Case management SOPs were finalized, with all provinces and infectious diseases hospitals identifying isolation and treatment space for COVID-19 case management.

IPC training of trainers (ToT) are ongoing with the support from UNICEF.

Gaps

- Decentralization of COVID-19 testing to provincial and district levels is key to improve on access to testing services.
- There is need to strengthen risk communication to create awareness on COVID-19 at all levels, and coordination across all pillars for an integrated and effective response.
- There are significant gaps in reagents for testing for COVID-19 and the availability of personal protection equipment (PPE) including laboratory coats, head covers, shoe covers and gloves.
- There is a need for strengthening contact tracing for the confirmed cases in view of local transmission; strengthening capacity for entry screening of all arrivals at the international airports and key points of entry following confirmation of imported cases; intensifying in-country surveillance in view of border closures, deportations and migration from urban to rural areas; and scaling up of training key health workers at identified isolation sites in conformity with WHO guidelines for detection and response to COVID-19 transmission.
- Institutional arrangements with private health care actors need strengthening to coordinate information on screening, testing and treatment of COVID-19 as well as indications of continuing operations and health service delivery.
Approximately 100,000 children under age 5 are suffering from acute malnutrition, with a national GAM prevalence rising from 2.5 per cent of reported in ZimVAC 2018 to 3.6 per cent in ZimVAC 60 districts rural 2019. A total of 8 districts recorded GAM prevalence of over 5 per cent.

From the newly released ZimVAC 2020, the national GAM prevalence remained more or less the same (3.7 per cent) with Matabeleland North (5.7 per cent) and Mashonaland Central (5.3 per cent) recording the highest. The National SAM prevalence is 1.45 per cent which is not acceptable according to prevalence cut off values for public health significance (ZimVAC 2020).

The nutrition status of children in Zimbabwe is further compounded by suboptimal infant and young child feeding practices including very poor dietary diversity at 15 per cent and with only 7 per cent having attained the minimum acceptable diet.

Due to the drought-induced food insecurity, most of the households in the country require food assistance to facilitate adequate dietary intake and prevent deterioration of the nutrition status of children, women and the general community. Already nationally 56 per cent of women consume less than five groups of foods recommended.

Active screening continues for early detection, referral and treatment of children with acute malnutrition.

Procurement and pre-positioning of life-saving therapeutic foods has been provided at all public health facilities in the country.

Micronutrient supplements including Vitamin A are provided.

Support and counselling has been given to mothers and caregivers of children under age 2 in IYCF-e.

Capacity building is provided for health workers and partners in nutrition in emergencies and nutrition communication for the emergency response at community level.

A total of 2,533 children under age 5 were admitted for treatment of severe acute malnutrition in 2020. All children identified with acute malnutrition were referred for treatment at the nearest health facility. Integrated nutrition and vaccination campaigns contributed substantially to the coverages reached.

Accountability to affected populations was facilitated through community dialogues.

Limited funding to meet the needs of the response remains the main challenge for the emergency nutrition projects.

Lack of disaggregated data on children with disabilities remains a gap as these data are not routinely collected.
Protection (Child Protection)

Needs

- Economic stress, further increased by the impact of COVID-19 lockdown on those dependent on the informal economy for their survival, anxiety surrounding the COVID-19 outbreak and living in lockdown without access to basic services, increases stress in households, psychosocial distress and depression in children and caregivers, resulting in increased risk of sexual and other forms of violence and abuse, and separation from caregivers for survival.

- The few social cash transfer and food deficit mitigation measures that are operational, do not benefit children living in institutions resulting in dire circumstances for a group of extremely vulnerable children.

- Children on the streets are being rounded up and moved outside of urban centres to places of safety, including residential care facilities and training centres. These centres lack the bare minimum of basic services to maintain adequate personal hygiene and services to care for them.

Response

- Since January 2020, 15,763 children (57 per cent boys and 43 per cent girls) have benefited from structured psychosocial activities.

- A Child Protection sub-cluster contingency plan for COVID-19 was developed and was integrated with the Protection Cluster contingency plan.

- Child Protection implementing partners have revised working modalities, including case management through mobile phone, online family tracing by social workers, procurement of PPE for implementing partners, additional staffing for online reporting of sexual abuse or psychosocial counselling of children. PSEA and MHPSS are integrated in COVID-19 messages for community cadres, children and caregivers. Funding agreements with UNICEF were updated accordingly.

- Alternative care arrangements for children on the streets—for cities including Harare, Bulawayo, Masvingo, Gweru and Mutare—have been made, with 59 children already placed in the Ruwa Training Centre with caregivers and social workers having been drawn from other local institutions.

Gaps

- The COVID-19 lockdown has had a significant impact on access and quality of child protection services. Even though GBV and child protection services are designated by Government as essential services, most child protection service providers have temporarily halted their services to revise strategies to deliver services through online platforms and for sourcing PPE.
GBV threats continue to intensify in scale and scope while the population is exposed to degenerating food insecurity. Food insecurity, compounded by economic hardship, jeopardizes the capacity of affected populations to access basic services such as health & education, leading to increases in school drop-out rates, child marriage and teenage pregnancies, with further negative—and often fatal—consequences for the sexual and reproductive health of young women and girls.

GBV exacerbation is expected as an indirect consequence of COVID-19 infection prevention and control (IPC) measures. The lockdown restrictive measures have an impact on the women's and girls' ability to access basic family resources (e.g. fetching water, accessing food), generating an increase of tensions within the household, which leads to increased risks of exposure to intimate partner violence (IPV) as well as to sexual exploitation and abuse.

GBV service facilities are currently not equipped for COVID-19 infection prevention and control measures which poses high risks of infection for both staff and clients. Furthermore, access to GBV services is constraint due to the limited freedom of mobility and reduced availability of public transport means during lockdown.

### Response

Since 1 January 2020, the GBV sub-cluster partners have assisted a total of 2,275 individuals (939 male, 1,336 female) with community-based GBV risk mitigation and 595 GBV survivors (576 female, 19 male) with multisectoral services.

The GBV sub-cluster contingency plan for COVID-19 response was developed and partners have initiated a process of revision of service delivery modalities within the lockdown phase as of 30 March.

Key interventions include scaling up mobile service delivery; equipping all static and mobile GBV facilities (one-stop centers (OSCs), shelters and safe spaces) with COVID-19 IPC supplies; transport support for referral of survivors to higher level of care, including those with suspicious symptoms to COVID-19 dedicated response health facilities; scaling up remote psychosocial support (PSS), through increased capacity of GBV hotlines; increased GBV COVID-19 impact surveillance, MHPSS support for GBV service providers, community based communication for COVID-19 and GBV impact risks mitigation, capacity building of inter-cluster frontline responders on COVID-19 and GBV.

### Gaps

COVID-19 lockdown measures have in some instances resulted in constraints of movement for GBV services staff, undermining service continuity. This challenge has been addressed through close collaboration with the Ministry of Women's Affairs, Community, Small and Medium Enterprises Development (MOWACSMED), who is facilitating clearance for all GBV life-saving service providers for inclusion among critical services.

Funding gaps continue to prevent the GBV sub-cluster capacity to address the needs of most vulnerable women and girls, including to effectively mitigate the risk of exposure to GBV, surveillance and service provision in drought affected districts.
CLUSTER STATUS (10 Apr 2020)

Water, Sanitation and Hygiene (WASH)

<table>
<thead>
<tr>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>People targeted: 2,7M</td>
</tr>
<tr>
<td>People reached: 243K</td>
</tr>
</tbody>
</table>

- In rural areas, of the 55,593 water sources tracked by the rural water information management system (RWIMS), only 30 per cent have water, and are functional and protected, which increases the risk of WASH-related diseases, especially in 23.8 per cent of households lacking improved access. About 16 per cent of households travel more than 1 kilometre to fetch water from the nearest primary water source.

- Despite no reported cases of cholera, there is an ongoing typhoid outbreak with 488 cases and 2 deaths recorded in high-density suburbs of Harare.

- Urban centres face critical water treatment chemicals’ shortages and severe electricity power cuts, which has reduced the pumping capacity of water to residents resulting in water rationing in the regime of 2 days per week.

Response

- During the reporting period, the WASH sector launched the COVID-19 response plan to respond to 2.5 million people. Ongoing activities include: Setting up and promoting handwashing at 80 vegetable markets places within Harare City; support by WASH Rapid Response teams working on contact tracing with sanitizers, face masks and gloves to reduce the transmission of the virus.

- In addition, 40 boreholes were repaired in Harare City, with additional borehole materials to support the rehabilitation of 60 boreholes within critical areas in Harare, support to kick start a response in Mutare and Chipinge urban, and the activation of contingency partnership agreements with three cluster partners.

- Masvingo Province, making use of the UNICEF-supported contingency stock, has distributed soap and buckets to support hand washing in the province targeting institutions. With each district to receive 115 posters on hand washing, 20 bars of soap, 42 jerry cans and 40 buckets with taps to support hand washing activities, as well as 1,600 strips of aquatabs to support water treatment, the seven districts of Chivi, Zaka, Bikita, Masvingo, Gutu Mwenezi and Chiredzi have received these materials. In addition, Morganster hospital, the COVID-19 isolation centre, has also received 40 jerry cans, a box of aquatabs, 30 buckets with taps and 20 bars of soap and 115 hand-washing posters.

Gaps

- While still mobilizing resources for the response which is affecting the scale up, cluster partners have reallocated existing budgets to support the COVID-19 response, having a bearing on the ongoing drought response and cholera preparedness.

- Constraints are being felt for the supply of PPE due to the closure of borders and the increased demand of the materials globally.

- The COVID-19 lockdown is resulting in supply chain constraints on other WASH-related products.
CLUSTER STATUS (10 Apr 2020)

General Coordination

Needs

- An emergency of this complexity and magnitude requires the close coordination of all stakeholders. The interaction with Government and frontline ministries, UN agencies and operational partners is vital in rolling out the multisectoral humanitarian support to complement Government's interventions.

- Continuous tracking of response progress, funding availability and resource capacity is key to ensure that critical gaps are identified and dealt with.

- There is a need for increased coordination and information management under the government-led COVID-19 coordination structure with humanitarian and development partners, including communication of priority needs and gaps under the 10 pillars.

Response

- A Standing Cabinet Committee, under the stewardship of the Minister for Local Government and Public Works, is tasked with overseeing the Government’s response efforts and coordinates with the humanitarian partners through the office of the UN Resident Coordinator. At the technical and operational level, the Department of Civil Protection (DCP) coordinates the overall Government response with OCHA and UN cluster lead agencies, and interacts with Provincial and District administrations.

- On 19 March 2020, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched with an initial eight pillars of coordination, the creation of a national COVID-19 Response Task Force and the formation of the Inter-Ministerial Committee. Overall high-level coordination and planning is led by the Permanent Secretary for the Ministry of Health and Child Care (MOHCC) working with permanent secretaries of other ministries in support of the Inter-ministerial COVID-19 Task force, with weekly high level coordination meetings on Tuesdays in the Emergency Operations Centre.

- Humanitarian partners and donors meet bi-weekly (and ad-hoc if necessary) under the Humanitarian Country Team (HCT), chaired by the UN Resident Coordinator. Individual sectors also meet on a regular basis and are chaired and co-chaired by the relevant line ministries and humanitarian cluster lead agencies. Inter-cluster coordination meetings take place (bi-)weekly chaired by OCHA. Due to the COVID-19, all meetings are being held virtually.

Gaps

- Only 11 per cent of the total requested has been committed, and this critical funding gap hinders operational coordination of the response.

- Continuity of coordination personnel/expertise is not assured, and this presents operational difficulty where frequent personnel turnover is required during the HRP timeframe.

- Despite that the 21-day nationwide lockdown that started on 30 March 2020 to curb the spread of COVID-19 ensures the continuity of essential services, including humanitarian cluster activities, implementation and coordination have been constrained.
OCHA coordinates the global emergency response to save lives and protect people in humanitarian crises. We advocate for effective and principled humanitarian action by all, for all.

https://www.unocha.org/southern-and-eastern-africa-rosea/zimbabwe
https://reliefweb.int/country/zwe
https://www.humanitarianresponse.info/en/operations/zimbabwe